

Level II.1: Intensive Outpatient –Child and Adolescent SA

Definition

The following is based on the Youth Criteria of the Patient Placement Criteria for the Treatment of Substance-Related Disorders of the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R or current version) pages 217-233. Providers are responsible to refer to the ASAM PPC-2R Youth Placement Manual for complete criteria.

Intensive Outpatient Programs (IOP) for children and adolescents provide, multidisciplinary, multi-modal, structured treatment in an outpatient setting. Services are based on the individual's medical need. Such programs are less intensive than partial hospital and day treatment programs but significantly more intensive than traditional outpatient substance abuse therapy. Intensive Outpatient Services provide some group and individual based, non-residential, intensive, structured interventions consisting primarily of counseling and education about substance related and co-occurring mental health problems. This community based service allows the individual to apply skills in "real world" environments. Such treatment may be offered during the day, before or after work or school, in the evening or on a weekend. The service also provides a coordinated set of individualized treatment services to persons who are able to function in a school, work, and home environment but are in need of treatment services beyond traditional outpatient programs. Treatment may appropriately be used to transition persons from higher levels of care or may be provided for persons at risk of being admitted to higher levels of care. Clinical interventions should include modalities that utilize structured, evidence informed, culturally competent approach, or one approved by the managed care entity and Medicaid as part of the IOP service. Mandatory interventions include: individual, group and family psychotherapy, and psycho-educational services. Family involvement from the beginning of treatment is extremely important and, unless contraindicated, must occur at least once weekly. Coordination of school performance is an important component of treatment planning as is involvement with school personnel to monitor the ongoing impact of treatment and facilitate constructive ways of working with children/adolescents.

Policy

Substance abuse/mental health intensive outpatient services are available to youth aged 20 and younger.

Program Requirements

Medicaid providers of substance abuse treatment services will adhere to all criteria outlined in the American Society of Addiction Medicine, Second Edition Revised (ASAM PPC-2R) or most current edition. Refer to the program standards common to all levels of care for general requirements.

Licensing/Accreditation

Accreditation is not required for this service. The agency must be credentialed by the managed care entity. Each individual clinical staff member must be licensed as defined by the Department of Health and Human Services Division of Public Health Licensure Unit.

The provider is responsible to acquire any additional licensing that may be needed by contacting the Division of Public Health Licensure unit.

The agency must have written policies and procedures related to:

The agency must have written policies and procedures related to the provision of Intensive Outpatient Treatment Services. Refer to “Standards Common to all Levels of Care” for a potential list of policies generally related to the provision of mental health and substance abuse treatment. Agencies must develop policies to guide the provision of any service in which they engage clients, and to guide their overall administrative function.

Features/Hours

This service may be available 7 days/week after school, evenings and weekends. Intensive Outpatient Treatment may be provided up to 15 hours per week and no less than 9 hours depending on individual need and determination of the MMCE. These services must be provided by licensed clinicians. The service must be available to meet the needs of the youth and their family. The provider must identify their scheduled service hours in their program description. The service must provide or otherwise demonstrate that youth and family have on-call access to a licensed mental health provider on a 24-hour, seven-day per week basis.

Service Expectations

- A pre-treatment assessment (Biopsychosocial Assessment including a comprehensive substance abuse assessment and Initial Diagnostic Interview) that identified IOP as the recommended treatment service must be obtained by the IOP provider prior to the initiation of IOP.
- An initial plan will be developed with the multidisciplinary treatment team within 72 hours of admission, which includes the youth and their family, based on the referring practitioner’s comprehensive assessment until the Supervising Practitioner can complete the face to face diagnostic interview and the treatment plan and discharge plan is developed.
- The Supervising Practitioner for the program must complete a face-to-face, Initial Diagnostic Interview within 7 calendar days of admission and a face-to-face treatment intervention with the client at least every 30 calendar days after the Initial Diagnostic Interview
- Complete additional assessments and screenings as determined by the supervising practitioner. Assessment must take place as an ongoing activity throughout the treatment episode.
- Multidisciplinary team which includes the youth and their family develops and signs a family centered, outcome focused comprehensive treatment and discharge plan within 10 calendar days of admission.
- The multidisciplinary team consists of the youth, family, therapist/licensed clinician, supervising practitioner and other supportive individuals identified by the youth and their family
- Treatment interventions should be outcome focused based on the comprehensive assessment, treatment goals, culture, expectations, and needs as identified by the youth and their family.

- The individual treatment/recovery and discharge plan is reviewed by the treatment team as frequently as medically indicated, but at a minimum of every 30 calendar days, and signed by the supervising practitioner and the additional multidisciplinary team members
- Medication management and youth/family education (expected benefits, potential side effects, potential interactions, dosage, obtaining/filling prescriptions, etc.)
- The following mandatory interventions must include: ongoing assessment, individual, group and family psychotherapy, psycho-educational services
- Adjunctive therapies such as life skills, community support building, leisure skill building, time management, pre-vocational skill building, and health education (nutrition, hygiene, medications, personal wellness, etc) may also be a part of the treatment program.
- Family interventions must relate to the youth's treatment plan and includes skill building regarding substance abuse and mental health symptom management. This may include: de-escalation techniques, behavioral management techniques, coping skills, assisting the youth with social and life skills development, child development, medication compliance, and relapse prevention.
- Awareness and skill development for youth and/or family in regards to accessing community resources and natural supports that could be used to help facilitate youth/family efficacy and increase youth function without the support of ongoing Intensive Outpatient Therapy
- Consultation and/or referral for general medical, psychiatric, vocational, psychological, educational services and psychopharmacology needs
- It is the provider's responsibility to coordinate with other treating professionals
- Discharge planning starts at admission and must be included in the treatment plan and all treatment plan reviews. Prior to discharge the IOP staff must facilitate, confirm, and document that contacts are made with the identified community service or treatment provider as identified in the discharge plan.

Staffing Requirements

Supervising Practitioner: (Psychiatrist, Licensed Psychologist, Licensed Independent Mental Health Practitioner (LMHP))

The responsibilities of the Supervising Practitioner include but are not limited to the following:

- Assume accountability to direct the care of the client at the time of admission
- Provides guidance in the development of the treatment/discharge plan
- Provide face-to-face service to the client at least every 30 days (or as medically necessary) to include a diagnostic assessment or a review the effectiveness of the treatment plan
- Attend treatment planning meetings at a minimum of every 30 days to provide supervision and direction to the treatment team
- Provide supervision and direction with crisis situations

Program/Clinical Director: (LMHP, Psychiatric RN, APRN, LIMHP, Licensed Psychologist, Dual Licensure (e.g. LMHP/LADC or LMHP/PLADC) is required for Dual IOP (MH/SA) programs)

A clinician fully licensed by the State of Nebraska, who is providing services within his/her scope of practice and licensure, and has two years of professional experience in the

psychiatric treatment of children and adolescents. This clinician has professional experience in a treatment setting similar to that for which the clinician is providing services of the program director. If an APRN is utilized they must have a psychiatric specialty, and work in collaboration with a psychiatrist

The responsibilities of the Program/Clinical Director include but are not limited to the following:

- Oversees, implements, and coordinates all treatment services and activities provided within the program.
- Continually incorporates new clinical information and best practices into the program to assure program effectiveness and viability.
- Oversees the process to identify, respond to, and report crisis situations on a 24 hour per day, 7 day per week basis.
- Responsible in conjunction with a supervising practitioner for the program's clinical management
- Assures quality organization and management of clinical records, other program documentation, and confidentiality.

Therapist/licensed clinician: (LMHP, LIMHP, PLMHP, LADC, Licensed Psychologist, Provisionally Licensed Psychologist, APRN, Licensed Psychiatrist)

The clinician(s) providing MH/SA services for youth in the treatment program must be operating within their scope of practice and meeting program requirements. If an APRN is utilized they must have a psychiatric specialty, and work in collaboration with a psychiatrist

The role and responsibilities of the therapist include but are not limited to the following:

- Reports to the Program/Clinical Director and Supervising Practitioner for clinical and non-clinical guidance and direction
- Communicates treatment issues to supervising practitioner as needed
- Provides individual, group, family psychotherapy, and/or substance abuse counseling
- Assists to develop and update treatment plans for individuals in their care in conjunction with the multidisciplinary team
- Provides input to the multidisciplinary team and attends treatment team meetings
- Provides continuous and ongoing assessment to assure the clinical needs of the youth and family are met. This includes transitioning of youth to other treatment and care settings, or other types of supports as necessary.

Staff Ratios

All staffing must be adequate to meet the individualized treatment needs of the client and meet the responsibilities of each staff position as outlined in the Staffing Requirements section to include:

- Supervising Practitioner: adequate to provide necessary services to admitted youth
- Program/Clinical Director: adequate to fulfill the expectations of this position
- Therapist/Licensed Clinician to individual served: 1 to 15 maximum clients

Training

Refer to “Standards Common to all Treatment Services” for a list of potential training topics related to the provision of mental health and substance abuse treatment. Agencies must provide adequate pre-service and ongoing training to enhance the capability of all staff to treat the individuals they serve and provide the maximum levels of safety for themselves and others.

Clinical Documentation

The program shall follow the agency’s written policy and procedures regarding clinical records that meet the accreditation body, Medicaid guidelines and the Managed Care Handbook. The agency’s policies must include specifics about timely record entry by all professionals and paraprofessionals providing services in the program.

The clinical record must provide information that fully discloses the extent and outcome of treatment services provided to the client. The clinical record must contain sufficient documentation to justify the Medicaid Managed Care service that was specifically delivered by the staff person, who it was delivered to and the frequency/duration of the service.

The record must be organized with complete legible documents. When reviewing a clinical record, a clinician not familiar with the client or the program must be able to review, understand and evaluate the mental health and substance abuse treatment for the client. The clinical record must record the date, time, and complete name and title of the facilitator of any treatment service provided to the client. All progress notes should contain the name and title of the author of the note including signature and when appropriate the signature of the Supervising Practitioner.

In order to maintain one complete, organized clinical record for each client served, the agency must have continuous oversight of the condition of the clinical record. The provider shall make the clinical record available upon Medicaid and/or the managed care entity’s request to review or receive a copy of the complete record. All clinical records must be maintained for seven years following the provision of services.

Length of Services

Length of service is individualized and based on clinical criteria for admission and continuing stay. Frequency and duration is expected to be adjusted based upon the symptoms and acuity of the mental health/substance abuse diagnoses for which they were admitted. As clients make progress toward treatment goals, frequency and duration of the service is expected to decrease. If progress is not being made and client stability is not increasing, the treatment plan must be adjusted to promote progress.

Special Procedures

None Allowed.

ASAM criteria for youth apply when the treatment need is for addiction services only treatment and when the treatment need is for an individual who has co-occurring symptoms and diagnoses (mental health and substance abuse).

Clinical Guidelines: Level II.1: Intensive Outpatient –Adolescent SA

Admission Guidelines:

1. The child/adolescent is assessed as meeting the diagnostic criteria for a Substance-Related Disorder or a co-occurring psychiatric disorder, as defined in the most recent DSM.
2. Direct **admission** to a Level II.1 program is advisable for the child/adolescent who meets the stability specifications in Dimension 1 (if any withdrawal problems exist) and Dimension 2 (if any biomedical conditions or problems exist) and the severity specifications in *one* of Dimension 3, 4, 5 or 6.
3. **Transfer** to a Level II.1 program is advisable for a child/adolescent who **(a)** has met the objectives of treatment in a more intensive level of care **and (b)** requires the intensity of services provided at Level II.1 in at least one dimension.
5. A child/adolescent also may be transferred to Level II.1 from a Level I program when the services provided at Level I have proved insufficient to address the individual's needs or when Level 1 services have consisted of motivational interventions to prepare the child/adolescent for participation in a more intensive level of service, for which he or she now meets the admission criteria.

The following six dimensions and criteria are abbreviated. ***Providers are responsible to refer to the ASAM PPC-2R***

Adolescent PLACEMENT MANUAL (pages 220-233) for the complete criteria.

- **DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL:**
The youth is not experiencing withdrawal acute or subacute withdrawal from alcohol or drugs and is not at risk for acute withdrawal or if the youth is experiencing mild withdrawal, the symptoms are minimal and are diminishing.
- **DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS:**
In Level I, the youth is not posing any biomedical conditions or complications and therefore is sufficiently stable to permit participation in outpatient treatment or the biomedical conditions are stable or are being concurrently addressed and will not interfere with treatment at this level of care.
- **DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS AND COMPLICATIONS:** Dangerousness/Lethality-The youth is at mild risk of behaviors endangering self, others, or property. Interference with Addiction Recovery Efforts- The youth recovery efforts are negatively affected by an emotional, behavioral or cognitive problem, which causes mild interference with and requires increased intensity to support treatment participation and/or compliance. Social Functioning- The youth's symptoms are causing mild to moderate difficulty in social functioning but not to such a degree that he or she is unable to manage the activities of daily living or to fulfill responsibilities at home, school, work or community. Ability for self care-The youth is experiencing mild to moderate impairment in this area and requires frequent monitoring and treatment interventions. Course of Illness-Emotional, behavioral or cognitive condition would become unstable without frequent monitoring.
- **DIMENSION 4: READINESS TO CHANGE:** The youth status is characterized by one of the following:
 - Youth requires structured programmatic milieu to promote progress through the stages of change

- Youth's perspective inhibits his or her ability to make progress through the stages of change.
- **DIMENSION 5: RELAPSE, CONTINUED USE OR CONTINUED PROBLEM POTENTIAL:** The youth is at significant risk of relapse or continued use as well as deterioration in level of functioning, without frequent therapeutic services. The youth demonstrates impaired recognition and understanding of relapse issues. He or she is able to avoid continues use or relapse only with the moderate treatment support at IL1 program.
- **DIMENSION 6: RECOVERY ENVIRONMENT:**
 - Continued exposure to the youth's current school, work or living environment will impede recovery.
 - The youth lacks social contacts, or has inappropriate social contacts that jeopardize recovery or has few friends or peers who do not use alcohol or other drugs.
 - The youth's family or caretakers are suppos4rtive of recovery, but family conflicts and related family dysfunction impede the ability to learn the skills necessary to achieve and maintain abstinence.

Exclusionary Guidelines:

1. N/A in ASAM. Please refer to admission and continued stay criteria as noted.
2. Treatment for Pervasive Developmental Disorders and/or adaptive limitations from Pervasive Development Disorders is ineligible for Medicaid reimbursement.

Continued Stay Guidelines:

It is appropriate to retain the individual at the present level of care if:

1. The individual is making progress but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

OR

2. The individual is not yet making progress, but has the capacity to resolve his or her problems. The individual is actively working toward the goals in the individualized treatment plan. Continued treatment at this level of care is assessed as necessary to permit the individual to continue to work toward his or her treatment goals.

AND/OR

3. New problems have been identified that are appropriately treated at this level of care. This level of care is the least intensive level of care at which the individual's new problems can be addressed effectively.

To document and communicate the individual's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the individual's existing or new problem (s), he or she should continue in treatment at the present level of care. If not, refer to the Discharge/Transfer Criteria.

Discharge/Transfer Criteria

It is appropriate to transfer or discharge the youth from the present level of care if he or she meets the following criteria:

1. The youth has achieved the goals articulated in his or her individualized treatment plan thus resolving the problem(s) that justified admission to the present level of care and the youth has a comprehensive relapse plan in place which is individualized for his/her specific needs.
OR
2. The youth has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service is therefore indicated.
OR
3. The youth has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service is therefore indicated.
OR
4. The youth has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the youth's readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the youth should be discharged or transferred, as appropriate.

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